DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 8

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 00 $ 49,797.00
b. FFY 01 $ 565,905.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D, pages 29, 49-65, 93, 96, 99

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D, pages 29, 49-65, 93, 96, 99

10. SUBJECT OF AMENDMENT:
Revision of the calculation in computing the use fee by changing the index from the Fannie Mae to the United States Treasury bond. Rate-setting criteria for HIV nursing facilities.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Karen Smith / Title for Kathleen D. Gifford

13. TYPED NAME:
Kathleen D. Gifford

14. TITLE:
Kathleen D. Gifford, Asst. Secretary - OMPP

15. DATE SUBMITTED:
December 28, 2000

16. RETURN TO:
Kathleen D. Gifford, Asst. Secretary
Office of Medicaid Policy and Planning
402 W. Washington St., Room W382
Indianapolis, Indiana 46204
ATTN: Tracy Brunner

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/29/00

18. DATE APPROVED: 3/15/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

DEC 29 2000

DMIO - IL/IN/OH

FORM HCFA-179 (07-92)

Instructions on Back

the date of facility acquisition to the present based on the change in the R. S. Means Construction Index.

(2) The inflation-adjusted historical cost of property per bed as determined above is arrayed to arrive at the average historical cost of property of the median bed.

(3) The average historical cost of property of the median bed as determined above is extended times the number of beds for each facility that are used to provide nursing facility services, to arrive at the fair rental value amount.

(4) The fair rental value amount is extended by a rental rate to arrive at the fair rental allowance. The rental rate shall be a simple average of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), in effect on the first day of the month that the index is published for each of the twelve (12) months immediately preceding the rate effective date as determined in section 6(a) of this rule. The rental rate shall be updated quarterly on January 1, April 1, July 1, and October 1.

405 IAC 1-14.6-13 Reporting of financing arrangements; working capital; interest; allocation of loans

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 13. (a) All patient-related property financing arrangements shall be fully and completely disclosed on the forms prescribed by the office.

Rule 14.5. Rate-Setting Criteria for HIV Nursing Facilities

405 IAC 1-14.5-1 Policy; scope
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified nursing facilities (NF) that provide skilled and intermediate nursing care for chronically medically dependent people infected by the human immunodeficiency virus (HIV). All payments referred to within this rule for the provider group and levels of care are contingent upon the following:
(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.
(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs which must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.
(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

405 IAC 1-14.5-2 Definitions
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 16-10-1

Sec. 2. (a) As used in this rule, "allowable per patient day cost" means a ratio between total allowable cost and patient days.
(b) As used in this rule, "annual or historical financial report" refers to a presentation of financial data, including appropriate supplemental data, and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.
(c) As used in this rule, the "Medicaid cost per patient day" means the sum of the direct care, indirect care, administrative and capital component medians calculated in accordance with 405 IAC 1-14.3. For providers of skilled nursing care for chronically medically dependent persons infected with the human immunodeficiency virus (HIV), the Medicaid cost per patient day is calculated by adding:

(1) the product of the direct care median times a Medicaid case mix level of 1.27;
(2) the indirect care median;
(3) the administrative median; and
(4) the capital component median.

For providers of intermediate nursing care for chronically medically dependent persons infected with the human immunodeficiency virus (HIV), the Medicaid cost per patient day is calculated by adding:

(1) the product of the direct care median times a Medicaid case mix level of .69;
(2) the indirect care median;
(3) the administrative median; and
(4) the capital component median.

The Medicaid cost per patient day shall be computed on a statewide basis and shall be maintained by the office with revisions made four (4) times per year effective April 1, July 1, October 1, and January 1.

(d) As used in this rule, "change of provider status" means a bona fide sale or capital lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties. The term does not include a facility lease transaction that does not constitute a capital lease under Financial Accounting Standards Board Statement 13 as issued by the American Institute of Certified Public Accountants in November 1976.

(e) As used in this rule, "chronically medically dependent" means a medical condition of a person who is infected by the human immunodeficiency virus (HIV) and has been certified by a physician as, because of the HIV infection, requiring a skilled or intermediate level of care as specified under 405 IAC 1-3-1 and 1-3-2.

(f) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(g) As used in this rule, "debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(h) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(i) As used in this rule, "equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year end.

(j) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(k) As used in this rule, "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(l) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(m) As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(n) As used in this rule, "like levels of care" means:

(1) skilled care provided in a nursing facility;

(2) intermediate care provided in a nursing facility;

(3) special skilled or intermediate services provided to persons who are chronically medically dependent because of HIV.

(o) As used in this rule, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients by providers of like levels of care.

(p) As used in this rule, "office" means the office of Medicaid policy and planning.

(q) As used in this rule, "ordinary patient related costs" means costs of services and supplies that are necessary in delivery of patient care by similar providers within the state.

(r) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(s) As used in this rule, "profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

(t) As used in this rule, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(u) As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies.

(v) As used in this rule, "special skilled or intermediate services" means medical and health care services that are provided to a patient who is:

(1) chronically medically dependent; and

(2) in need of a level of care that is less intensive than the care provided in a hospital licensed under IC 16-10-1.

(w) As used in this rule, "unit of service" means all patient care at the appropriate level of care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(x) As used in this rule, "use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule.

405 IAC 1-14.5-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) Generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider status transactions, unless otherwise prescribed by this rule.
(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.
(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:
(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;
(2) document such adjustments in a finalized exception report; and
(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.
(d) Each provider shall submit, upon request, confirmation that all deficiencies and adjustments noted in the field audit final written report have been corrected and are not present in the current period annual financial report. However, if deficiencies and adjustments are not corrected, the office may make appropriate adjustments to current and subsequent cost reports of the provider.
(e) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

(e) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual or historical financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, and quality of recipient care. The burden of demonstrating that costs are patient related lies with the provider.

405 IAC 1-14.5-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider.

405 IAC 1-14.5-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation or a new type of certified service, or for a change of provider status, shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service. Initial interim rates will be set at the greater of the prior provider's then current rate, if applicable, or the fiftieth percentile rate. Initial interim rates shall be effective upon certification or the date that a service is established, whichever is later. The fiftieth percentile shall be computed on a statewide basis for like levels of care using current rates of all nursing facility providers. The fiftieth percentile rate shall be maintained by the office, and a revision shall be made to this rate four (4) times per year effective on March 1, June 1, September 1, and December 1.

(b) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the

provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.

(c) The provider's historical financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income, excluding non-Medicaid routine income.

(5) Detail of fixed assets and patient related interest bearing debt.

(6) Complete balance sheet data.

(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period, and the rate effective date as defined by this rule; private pay charges shall be the lowest usual and ordinary charge.

(8) Certification by the provider that:

(A) the data are true, accurate, related to patient care; and

(B) expenses not related to patient care have been clearly identified.

(9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer, by the provider, and as such are true and accurate to the best of the preparer's knowledge.

(d) The base rate may be in effect for longer or shorter than twelve (12) months. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

(e) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(f) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation, and an extension has not been granted, the initial interim rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider.

(g) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

(h) The change of provider status shall be rescinded if subsequent transactions by the provider cause a capital lease to be reclassified as an operating lease under the pronouncements adopted by the American Institute of Certified Public Accountants.

405 IAC 1-14.5-6 Active providers; rate review; annual request; additional requests; requests due to change in law; request concerning capital return factor; computation of factor
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office.
(c) When changes to historical costs meet the requirements of section 5 of this rule, this section, and section 7 of this rule and amount to five percent (5%) or more of the historical cost of the facilities and equipment as reported on the most recent annual or historical report, the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. The change in the capital return factor shall be allowed subject to the difference between the capital return factor allowed before the change and the capital return factor allowed after the change. The capital return factor allowed after the change shall be computed using minimum occupancy levels specified in section 7(b) of this rule.

405 IAC 1-14.5-7 Request for rate review; occupancy level assumptions; effect of inflation
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 7. (a) Rate setting shall be prospective, based on the provider's annual or historical financial report for the most recent completed year. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.
(b) For nursing facilities, allowable costs per patient day for certain fixed costs shall be determined based on an occupancy level equal to the greater of ninety percent (90%) effective with the effective date of this rule or actual occupancy. The fixed costs subject to this minimum occupancy level standard include the capital return factor determined in accordance with sections 12 through 17 of this rule.

405 IAC 1-14.5-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient utilization.
(b) Each facility and home office shall be allowed only one (1) patient care-related automobile to be included in the vehicle basis for purposes of cost reimbursement under this rule. As used in this subsection, "vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds.

405 IAC 1-14.5-9 Criteria limiting rate adjustment granted by office
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs, plus a potential profit add-on payment. The payment rate is subject to several limitations. Rates will be established at the lowest of the four (4) limitations listed as follows:
(1) The Medicaid cost per patient day times one hundred fifteen percent (115%). This subdivision does not apply to private room rates.

(2) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services.
(3) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.
(4) Inflated allowable per patient day cost plus the allowed profit add-on payment. The profit add-on is equal to fifty percent (50%) of the difference (if greater than zero (0)) between a provider's inflated allowable per patient day cost, and one hundred ten percent (110%) of the Medicaid cost per patient day, calculated on a statewide basis. Under no circumstances shall a provider's profit add-on exceed ten percent (10%) of the Medicaid cost per patient day, calculated on a statewide basis.
(b) The rate for private rooms and the rate for rooms with three (3) beds or more shall be calculated using the ratio or percentage spread of the proposed private pay rates for those types of beds times the rate for rooms with two (2) beds, subject to the other limitations of this section.

405 IAC 1-14.5-10 Computation of rate; allowable costs; review of cost reasonableness
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.
(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.
(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care throughout the state. The office may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.
(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs

405 IAC 1-14.5-11 Allowable costs; services provided by parties related to provider
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 11. (a) Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control may be included in the allowable cost in the unit of service of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in an arm's-length transaction.
(b) Common ownership exists when an individual, individuals, or any legal entity possesses ownership or equity of at least five percent (5%) in the provider as well as the institution or organization serving the provider. An individual is considered to own the interest of immediate family for the determination of percentage of ownership. The following persons are considered immediate family:
(1) Husband and wife.
(2) Natural parent, child, and sibling.
(3) Adopted child and adoptive parent.
(4) Stepparent, stepchild, stepsister, and stepbrother.
(5) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(6) Grandparent and grandchild.
(c) Control exists where an individual or an organization has the power, directly or indirectly, to influence or direct the actions or policies of an organization or institution, whether or not actually exercised.
(d) Transactions between related parties are not considered to have arisen through arm's-length negotiations. Costs applicable to services, facilities, and supplies furnished to a provider by related parties shall not exceed the lower of the cost to the related party, or the price of comparable services, facilities, or supplies purchased elsewhere. An

exception to this subsection may be granted by the office if requested in writing by the provider before the rate effective date of the review to which the exception is to apply.
(e) The office shall grant an exception when a related organization meets all of the following conditions:
(1) The supplying organization is a bona fide separate organization.
(2) A sufficient part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier in common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.
(3) The services, supplies, or facilities are those which commonly are obtained by institutions, such as the provider, from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.
(4) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

405 IAC 1-14.5-12 Allowable costs; capital return factor
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.
(b) The capital return factor portion of the established rate is the sum of the allowed use fee, return on equity, and rent payments.
(c) Allowable patient care-related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this section.

405 IAC 1-14.5-13 Allowable cost; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 13. (a) The use fee limitation is based on the following:
(1) The assumption that facilities and equipment are prudently acquired and financed.
(2) Providers will obtain independent financing in accordance with a sound financial plan.
(3) Owner capital will be used for the balance of capital requirements.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years.

(c) The use fee component of the capital return factor shall be limited by the lesser of:
(1) the original loan balance at the time of acquisition;
(2) eighty percent (80%) of historical cost of the facilities and equipment; or
(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (1/2) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three

percent (3%), rounded to the nearest one-half percent (.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall only be recognized when the interest rate is less than the original financing, and the interest rate on the refinancing shall not be allowable in excess of the interest rate limit established on the date the refinancing commitment was signed and the interest rate fixed by the lender and borrower.

(g) Variable interest debt will be recognized for the purpose of calculation of the use fee if the variable rate is a function of an arrangement entered into and incorporated in the lending arrangement at the time of the acquisition of the facility or as part of an allowable refinancing arrangement under subsection (f).

(h) Interest costs on borrowed funds used to construct facilities or enlarge existing facilities which are incurred during the period of construction shall be capitalized as part of the cost of the facility or addition.

(i) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of actual revenues. Interest on such loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing patient related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

(j) Loans covering more than one (1) facility or asset shall apply to the several facilities or assets acquired in proportion to the cost that each item bears to the total cost. Accordingly, if any building or asset covered by the loan is used for purposes other than patient care, the use fee applicable to such assets will be determined based upon its proportionate share of the total asset cost.

(k) Loans from a related party must be identified and reported separately on the annual or historical financial report. Such loans shall be allowable if they meet all other requirements, the interest does not exceed the rate available in the open market, and such loans are repaid in accordance with an established repayment schedule.

(l) Use fee for variable interest rate mortgages will be calculated as follows:

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.

(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).

(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.

(4) The use fee on the prospective rate is the amount determined in subdivision (3) plus or minus the variance in subdivision (2).

405 IAC 1-14.5-14 Allowable costs; capital return factor; computation of return on equity component
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 14. (a) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

before the effective date of this rule, the return on equity shall be computed on the higher of twenty percent (20%) of the allowable historical cost of facilities and equipment, or actual equity in allowable facilities and equipment. Allowable historical cost of facilities and equipment is the lesser of the provider's actual historical cost of facilities and equipment or the maximum allowable property basis at the time of the acquisition plus one-half (1/2) of the difference between that amount and the maximum allowable property basis per bed on the rate effective date.

(b) For a provider with an initial interim rate resulting from:

(1) a change of provider status; or

(2) a new operation;

on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, thirty (30) year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

(d) The return on equity determined under this section shall be subject to the limitations under section 15(b) of this rule.

405 IAC 1-14.5-15 Allowable costs; capital return factor; use fee; depreciable life; property basis
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

Property Basis	Use Fee Life
Land	20 years
Land improvements	20 years
Buildings and building components	20 years
Building improvements	20 years
Movable equipment	7 years
Vehicles	7 years

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

Acquisition Date	Maximum Property Basis Per Bed
7/1/76	$12,650
4/1/77	$13,255
10/1/77	$13,695
4/1/78	$14,080
10/1/78	$14,630
4/1/79	$15,290
10/1/79	$16,115
4/1/80	$16,610
10/1/80	$17,490
4/1/81	$18,370
10/1/81	$19,140
4/1/82	$19,690
9/1/82	$20,000
3/1/83	$20,100
9/1/83	$20,600
3/1/84	$20,600
9/1/84	$21,200
3/1/85	$21,200
9/1/85	$21,200
3/1/86	$21,400
9/1/86	$21,500
3/1/87	$21,900
9/1/87	$22,400

3/1/88	$22,600
9/1/88	$23,000
3/1/89	$23,100
9/1/89	$23,300
3/1/90	$23,600
9/1/90	$23,900
3/1/91	$24,500
9/1/91	$24,700
3/1/92	$24,900
9/1/92	$25,300
3/1/93	$25,400
9/1/93	$25,700
3/1/94	$26,000
9/1/94	$26,300
3/1/95	$26,500
9/1/95	$27,300
3/1/96	$27,700
9/1/96	$28,000
3/1/97	$28,300
9/1/97	$28,600

The schedule shall be updated semiannually, effective on March 1 and September 1 by the office, and rounded to the nearest one hundred dollars ($100) based on the change in the R.S. Means Construction Index.

(b) The capital return factor portion of a rate that becomes effective after the acquisition date of an asset shall be limited to the maximum capital return factor which shall be calculated as follows:

(1) The use fee portion of the maximum capital return factor is calculated based on:

(A) the maximum property basis per bed at the time of acquisition of each bed, plus one-half (1/2) of the difference between that amount and the maximum property basis per bed at the rate effective date times eighty percent (80%);

(B) the term is determined per bed at the time of acquisition of each bed and is twenty (20) years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983; and

(C) the allowable interest rate is the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on:

(A) the allowable equity as established under section 14 of this rule; and

(B) a rate of return on equity that is the greater of United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (1/2) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.